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MARYLAND HEALTH CARE COMMISSION

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October 12, 2018

E-mail and USPS Mail

Jacob Minang, Ph.D.
Optimal Health Care, Inc.
6 West Washington Street, Suite 212
Hagerstown, Maryland 21740

**Re: CON Application to Authorize a
Residential Service Agency to Provide
Home Health Services in Upper Eastern
Shore
Matter # 18-R1-2426**

Dear Dr. Minang,

Commission staff has reviewed the above referenced application for Certificate of Need (“CON”) approval to authorize the applicant to provide home health services in the jurisdictions of the Upper Eastern Shore Region. Staff found the application incomplete, and accordingly, requests that you provide responses to the following questions:

Part I: Project Identification and General Information

1. Based on your target date of three months from CON approval date for Maryland HHA Licensure and CMS Medicare Certification, staff assumes that you are not aware of Medicare's Conditions of Participation. It is not within the Maryland Health Care Commission's authority to license or provide Medicare certification. As a result, you must contact Maryland's OHCQ and CMS for guidance on Conditions of Participation and calculating new target dates. Please provide a narrative about your understanding of the Maryland HHA Licensure and CMS Medicare Certification processes and adjust your time frame for becoming licensed and certified accordingly.

Part II: Consistency with Review Criteria at COMAR 10.24.01.08G(3)

Fees and Time Payment Plan

2. As requested in the standard and guidance provided at the pre-application conference, please cite the specific language, as well as a citation of the location, from the policy which describes the clients' time payment options and mechanisms to arrange payments.

Charity Care and Sliding Fee Scale

3. Please cite the sources for Charts 1 in your CON application.
4. Please fill in the chart for each of the following section of the Charity Care Policy Standard.

Standard	Quote from the policy	Section citation
10.24.16.08E Charity Care Policy. Each applicant for home health agency services shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:	N/A	N/A
(1) Determination of Eligibility for Charity Care and Reduced Fees. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.		
(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care, but are unable to bear the full cost of services.		

5. Please report the amount of charity care (% of visits that were charity care) provided by OHCInc for last three years in each of the jurisdictions that it currently serves, juxtaposed with the average amount of charity care provided by home health agencies. If this track record does not match the average level of charity care provided, please explain how the applicant can assure MHCC that it will comply with this standard for the five counties located in the Upper Eastern Shore.
6. Please submit a sliding fee scale and copy of public notice, as these documents were not received with submitted material. If official versions of these documents have not been created, submit a sample or draft of your sliding fee scale and public notices.
7. Please describe how the notices and policies will be disseminated to your service area. Make sure that your charity care and reduced fee policies are consistent with your notices and all forms, applications, and requests for documentation.
8. Please discuss your detailed plan for achieving the charity care level proposed.

Financial Feasibility

9. Please cite the sources for Charts 2 in your CON application.
10. Although Table 2A does not apply to RSA applicants, we would like to have some of this information so that staff can more fully understand OHCInc. Please fill out the modified version Table 2A below and submit a corresponding description of your current business.

	Two Most Current Actual Years		Current Actual Year Projected
CY or FY (circle)			
Client Visits			
Billable			
Non-Billable			
TOTAL			
# of Clients and Visits by Discipline			
Total Clients (Unduplicated Count)			
Skilled Nursing Visits			
Home Health Aide Visits			

Physical Therapy Visits			
Occupational Therapy Visits			
Speech Therapy Visits			
Medical Social Services Visits			
Other Visits (Please Specify)			

Impact

11. Please explain from where you intend to recruit your projected new FTEs?
12. Please discuss the on impacts that you entering the market will have on caseloads, staffing, and payor mix of existing providers in further detail.

Financial Solvency

13. As requested in the standard and guidance provided at the CON pre-application conference, please provide documentation that demonstrates your “ability to comply with the capital reserve and other solvency requirements specified by CMS” for a new Medicare-certified home health agency. This standard is specifically referring to a portion of the CMS Medicaid Certification process (Section 489.28 of 42 CFR Ch. IV, <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec489-28.pdf>) that was referenced in Question 1. Again, this process is not related to the Maryland Health Care Commission or CON Program. We cannot provide insight and you must contact CMS for guidance.

Discharge Planning

14. As requested in the standard and guidance provided at the pre-application conference, please demonstrate your ability to provide appropriate referrals to patients.

Performance on Quality Measures

15. Attachment H is illegible because the print is too small and very faint. Please send a legible version of Attachment H.

Proven Track Record in Serving all Payor Types, the Indigent and Low Income Persons.

16. In the past, has Optimal served indigent and low income persons? Discuss the types and amount of care provided to these persons over the past five years.
17. Please provide actual data on payor mix over the last three years by filling out a similar to Table 3, Section 4A and 4B. Alter the table so that it reflects five years of past Payor Mix information for you.

Proven Track Record in Providing a Comprehensive Array of Services.

18. Are there any specialized programs that you have offered in the past or are planning to offer if you are authorized to operate as a Home Health Agency?

Need

19. Please cite the sources for Charts 4 in your CON application.

Availability of More Cost-Effective Alternatives

20. As requested in the standard, please provide a response that addresses “why this project is a less costly and/or more effective alternative for meeting the needs identified than other types of projects or approaches.” The effectiveness of each alternative in meeting the project objectives should be evaluated and the cost of each alternative should be estimated.

Viability of the Proposal

21. Please cite the sources for Charts 5 in your CON application.
22. Attachment J states that the Applicant operated at a \$159,098 loss in CY 2017. Provide a statement detailing your plan to accomplish the goal of operating at a profit.
23. The standard states that, “In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant.” Attachment L states that the CPA “cannot provide ... any form of assurance on the client's financial statements.” This letter does count as adequate documentation to satisfy this standard. Please supply documentation to satisfy this standard.
24. Please address the probable impact of the project on the charges for core services you provide and will provide. In your response, you referred to the impact on cost only.

25. Please discuss the probable impact of the project on the cost for services provided by other home health agencies in the area. In your response, you referred to the impact on charges only.

Impact on Existing Providers

26. Please provide an analysis that addresses the impact of the proposed project on the volume of service provided by all existing home health providers in Caroline County, Cecil County, Kent County, Queen Anne's County, and Talbot County. Consider this multi-jurisdictional area's historical utilization and OHCInc's potentially adverse impact on existing providers.
27. Please provide source(s) and discuss logic used to make the prediction that there will be no impact to the health care delivery system.

Part IV: Tables

Table 3

28. Although Table 3 does not apply to RSA applicants, we would like to have some of this information so that staff can more fully understand OHCInc. Also, provide a statement containing the assumptions used to develop projections for its operating revenues and costs.

	Two Most Recent Years -- Actual		Current Year Projected
CY or FY (Circle)	20_	20_	20____
1. Revenue			
Gross Patient Service Revenue			
Allowance for Bad Debt			
Contractual Allowance			
Charity Care			

Net Patient Services Revenue			
Other Operating Revenues (Specify)			
Net Operating			

Table 4

29. Please specify what constitutes "Other Expenses".

Table 5

30. We would like to have some of this information so that staff can more fully understand OHCInc. Please fill out the modified version Table 5 below. Omit or change position titles as necessary.

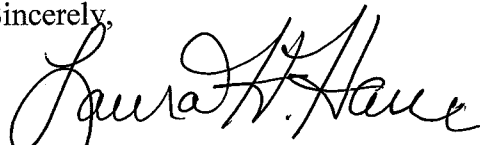
Position Title	Current No. of FTEs	
	Agency Staff	Contract Staff
2018		
Administrative Personnel		
Registered Nurse		
Licensed Practical Nurse		
Physical Therapist		
Occupational Therapist		
Speech Therapist		
Home Health Aide		
Medical Social Worker		
Other (Please specify.)		
Total		

Please submit four copies of the responses to the additional information requested in this letter within ten working days of receipt. (Note: extensions are provided routinely and available upon request). Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov).

All information supplementing the application must be signed by a person(s) available for cross-examination on the facts set forth in the supplementary information, and who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, feel free to contact me at (410) 764-5596.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Hare". The signature is fluid and cursive, with the first name "Laura" being more prominent than the last name "Hare".

Laura Hare
Health Policy Analyst

cc: Dyllis Minang, Ph.D. Candidate, MSN, Optimal Home Health Care
Kevin McDonald, Chief of Certificate of Need
Scott T. LeRoy, Caroline County Health Officer
Leland Spencer, M.D., Kent County Health Officer
Joseph Ciotola, M.D., Queen Anne's County Health Officer
Fredia Wadley, M.D., Talbot County Health Officer
Linda Cole, Chief of Long Term Care Planning
Cathy Weiss, Long Term Care Planning